

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2758AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2009
NAME OF PROVIDER OR SUPPLIER THE WATERFIELD MEMORY CARE COM		STREET ADDRESS, CITY, STATE, ZIP CODE 8880 W TROPICANA AVE LAS VEGAS, NV 89147		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 3/27/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 52 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 35. Ten resident files were reviewed and ten employee files were reviewed. Zero discharged resident files were reviewed. The following deficiencies were identified:	Y 000		
Y 278 SS=C	449.2175(9)(a)(b) Dietary Consultant - More Than 10 Residents NAC 449.2175 9. A residential facility with more than 10 residents shall employ or otherwise obtain the services of a person to serve as a consultant for the planning and serving of meals who: (a) Is registered as a dietitian by the Commission on Dietetic Registration. (b) Is a graduate from an accredited college with a major in food and nutrition and has 2 years of supervisory experience in a medical facility or facility for the dependent or has participated in a course of training for a supervisor of the service	Y 278		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2758AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2009
NAME OF PROVIDER OR SUPPLIER THE WATERFIELD MEMORY CARE COM			STREET ADDRESS, CITY, STATE, ZIP CODE 8880 W TROPICANA AVE LAS VEGAS, NV 89147		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 444	Continued From page 2	Y 444			
Y 444 SS=C	449.229(9) Smoke Detectors NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility. This Regulation is not met as evidenced by: Based on record review on 3/27/09, the facility failed to ensure smoke detectors were tested 11 out of the past 12 months (03/08, 04/08, 05/08, 06/08, 07/08, 08/08, 09/08, 11/08, 12/08, 01/09 and 2/09). Severity: 1 Scope: 3	Y 444			
Y 830 SS=C	WAIVERS 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734 , inclusive.	Y 830			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2758AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2009
NAME OF PROVIDER OR SUPPLIER THE WATERFIELD MEMORY CARE COM			STREET ADDRESS, CITY, STATE, ZIP CODE 8880 W TROPICANA AVE LAS VEGAS, NV 89147		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 830	Continued From page 3 This Regulation is not met as evidenced by: Based on record review and interview on 03/27/09, the facility failed to request a hospice waiver for 5 of 5 sampled hospice residents (Resident #2, #5, #6, #7 and #10). Severity: 1 Scope: 3	Y 830			
Y 859 SS=D	449.274(5) Periodic Physical examination of a resident NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician. This Regulation is not met as evidenced by: Based on record review and interview on 03/27/09, the facility failed to ensure 2 of 10 residents received a pre-admission or an annual physical (Resident #4 and #5). Severity: 2 Scope: 1	Y 859			
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order	Y 878			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2758AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2009
NAME OF PROVIDER OR SUPPLIER THE WATERFIELD MEMORY CARE COM			STREET ADDRESS, CITY, STATE, ZIP CODE 8880 W TROPICANA AVE LAS VEGAS, NV 89147		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 878	Continued From page 4 NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on observation, interview and record review on 03/27/09, the facility failed to ensure 2 of 10 residents received medications as prescribed (Resident #1 and #6). Severity: 2 Scope: 1	Y 878			
Y 936 SS=E	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations	Y 936			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2758AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2009
NAME OF PROVIDER OR SUPPLIER THE WATERFIELD MEMORY CARE COM			STREET ADDRESS, CITY, STATE, ZIP CODE 8880 W TROPICANA AVE LAS VEGAS, NV 89147		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 936	Continued From page 5 adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review on 03/27/09, the facility failed to ensure 3 of 10 residents complied with NAC 441A.380 regarding tuberculosis (Resident #1, #5 and #6). Severity: 2 Scope: 2	Y 936			
Y 999 SS=F	449.2754(1)(g) Alzheimer's Facility NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. This Regulation is not met as evidenced by: Based on observation on 3/27/09, the facility failed to ensure all toxic substances were inaccessible to the residents. In 5 of 5 sampled resident bathrooms lotion and liquid soap was observed unsecured. Severity: 2 Scope: 3	Y 999			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.